Healthy Homes Mississippi

Formula Grant Program

Mississippi Department of Human Services

Mississippi State Department of Health

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Narrative Table of Contents

Healthy Homes Mississippi

Updated State Plan

Narrative

Section I: Identification of Targeted At-Risk Communities

Demographics and County Descriptions

The at-risk communities selected for the continued effort of the Healthy Homes Mississippi home visiting program are clustered into two groups: Claiborne, Copiah, Jefferson and Wilkinson counties in southwest Mississippi and Coahoma, Tallahatchie and Tunica counties in northwest Mississippi. As with much of the state, most households in both group locations are in unincorporated areas.

For the southwestern group, Claiborne, Jefferson and Wilkinson share the Louisiana border to the west and Copiah abuts Jefferson and Claiborne on the east. Copiah is the most populous of the counties (29,094), followed by Claiborne (10,775), Wilkinson (10,143) and then Jefferson (8,928). Household data show that in all four counties the majority of residents are either African-American or White; other racial groups make up less than 1% of the population. The populations of Claiborne, Jefferson and Wilkinson counties are majority African-American (84%, 86% and 70%, respectively); however, the racial distribution in Copiah County is almost equal for African-American and Whites (51% and 48%).

For the northwestern group, Coahoma and Tunica share the Louisiana border to the west. Coahoma is the most populous of the counties (26,936) followed by Tunica (10,436). Household data show that in both counties the majority of residents are either African-American or White; persons of Hispanic or Latino origin make up between 2% and 5% while other racial groups make up roughly 1% of the population. The populations of Coahoma and Tunica counties are majority African-American (76% and 74% respectively).

When examining factors related to maternal and child health, both groups of counties fare worse than the statewide average on almost all indicators. The lone exception is the rate of teen pregnancy in Claiborne and Wilkinson counties and the premature birth rate in Tunica. However, given the exceptionally high rate of teen births in the state, the lower rate in these two counties is not remarkable. For all counties, the number of people living below the poverty level exceeds statewide levels and when it comes to children under the age of 18, these statistics become even more alarming. The unemployment rate in Claiborne and Jefferson counties is approaching twice the statewide average while Tunica is over four times the statewide average. (See Table 1a & 1b for details.)

Table 1. Select Demographics of Target Counties for Southwestern County Group								
	Premature Births (%)	Infant Mortality Rate	Teen Pregnancy	Low Birth Weight (%)	% Poverty		Un-Employment	HS Dropout
					All	Under 18		
Claiborne	23.4	10.3	37	16.4	34	48	12.4	6.2
Copiah	24.1	10.9	50	17.2	23.3	37	8.1	19.4
Jefferson	22.1	14.2	45.6	16.7	35.2	43	14.3	14.4
Wilkinson	19.5	7.1	38.5	16.7	35.1	37.3	9	10.2
State	17.8	10.3	41.5	12.2	20.1	29.7	7.3	16.8
Select Demographics of Target Counties for Northwestern County Group								
Coahoma	26.1	15.5	57.7	15.9	34.4	52.3	10.1	16.8
Tunica	16.5	20.1	83.2	13.8	25.4	40.4	31.1	31.1
State	17.8	10.3	41.5	12.2	20.1	29.7	7.3	16.8

Access to health care and health care providers is limited in both parts of the state, particularly in the areas of reproductive and gynecologic services and mental health. In the 2009 needs assessment conducted by the Department of Human Services, services were considered lacking in the following areas: *Coahoma County*: timely psychological/psychiatric assessments; timely forensic interviews; resource centers to address the individual needs of families. *Claiborne County*: family therapy for substance abuse issues and timely mental health assessments; *Copiah County*: parenting classes specialized by age of children and for teen parents; full scale mental health services; *Jefferson County*: timely appointments with the doctor; *Tunica County*: resource centers to address the individual needs of families; and *Wilkinson County*: timely psychological assessments; family therapy for substance abusers; transitional living services for teens. The home visiting model that we have selected requires that each participant receive assistance in establishing a medical home, which will assist them in locating needed services, where available. Residents do have access to some health services through public sources, but providers are limited and not all county offices are open every weekday. Claiborne and Copiah counties are served by District 5 of the Mississippi State Department of Health; Jefferson and Wilkinson are in District 7. Offices are closed on Thursdays in Claiborne and Jefferson counties. For those in rural areas of the county, transportation presents an additional challenge. Coahoma and Tunica are in District 1. Offices are open Monday through Friday.

Existing Home Visiting Services

In terms of existing home visiting programs, services are limited and are currently available to select residents of Coahoma, Copiah and Tunica; there are no home visiting services for Claiborne, Jefferson and Wilkinson.

The Metropolitan Infant Mortality Elimination Project (MIME) and Delta Infant Mortality Elimination (DIME) are both collaborative efforts between the Mississippi State Department of Health and the University of Mississippi Medical Center (UMMC). MIME recruits participants from Copiah County. DIME recruits participants from Coahoma, Tallahatchie and Tunica. Its goal is to prevent subsequent low birth weight births and reduce infant mortality among women who have previously given birth to a very low birth weight infant (VLBW), i.e., 3.2 pounds or less. The program provides 24 months of primary, continuous health care, dental screenings, enhanced nurse case management, and community outreach via a resource mother or resource worker. Primary health care addresses key areas epidemiologically linked to a VLBW delivery.

Initial eligibility targeted African-American mothers who either gave birth at the University of Mississippi Medical Center or had their child transferred there after birth. The number of women enrolled in this program is relatively small; the 2010 State Infant Mortality Report indicated that 19 women had been enrolled in the project, even though the coverage area includes the city of Jackson, which is the state capital and the most populous city. MIME/DIME do not use a standard home curriculum. The model on which the program is based was developed at Grady Memorial Hospital, Atlanta and that protocol is being replicated in MIME/DIME.

As recent as the summer of 2010, Parents as Teachers had a site in Copiah County. Funding was administered through the County Board of Supervisors. According to a member of the Board, the program was discontinued amid questions from the Board about the program's operations. The member could not provide additional information about the program's closure and current contact information for those directly involved with implementation of the program was not available.

The Healthy Start Program is an initiative of the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau. Its mandate is to reduce the rate of infant mortality and improve perinatal outcomes through grants to project areas with high rates of infant mortality in one or more subpopulations. Grantees are required to implement five core service components: outreach, case management, health education, perinatal depression screening and inter-conception and coordination with Title V and sustainability. Healthy Start in Mississippi is implemented by Delta Health partners. The program uses a team case management approach consisting of a nurse, a social worker and an outreach worker. Three case management teams provide services to pregnant and inter-conception teens and their children in the Mississippi Delta counties including Coahoma, Tallahatchie and Tunica.

Existing Resources and Coordination of Services

Although many of these residents live in small communities which typically have limited resources, social and medical services are available through organizations based in larger towns and cities. The 2009 Department of Human Services Needs Assessment identified other services to which families may be referred (see Table 2). As can be seen, many of the resources are directed toward meeting basic needs: food, clothing, utility assistance, etc. Substance abuse treatment services are available through the State Department of Mental Health, but beds are limited. Those centers serving these counties have 56 beds available for adult males and females in the southwestern counties and 48 beds available. The only available adolescent treatment center is located in Coahoma County with 24 (male/female) beds; adolescent treatment for other counties will require travel outside the community.

Table 2. Existing Resources in Selected Counties			
Counties Served	Agency Name	Services Provided	Location
Coahoma	Region 1 Mental Health Center	Parenting Classes Family Therapeutic Sessions Out-patient therapeutic and counseling services for youth experiencing substance / sexual abuse. Assist with locating in-patient services for youth.	Clarksdale
Copiah; Jefferson; Wilkinson	Southwest MS Opportunity, Inc.	Case management; weatherization; commodities; parenting and anger management classes; substance abuse prevention	McComb; Tylertown
Copiah; Jefferson; Wilkinson	Southwest Mississippi Planning and Development	Clothes; food, utility, rent and prescription assistance; child care management agency; workforce development; elder care services	Meadville
Copiah; Claiborne; Jefferson; Wilkinson	Southwest MS Children's Advocacy Center	Forensic Interviews	McComb
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	Southwest MS Mental Health	Mental Health Services	Clarksdale; Monticello; therapy (Wed.); Port Gibson; Fayette; Tunica; Gloster, Woodville
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	Food and Nutrition Service, USDA	WIC Distribution Center	Clarksdale; Hazlehurst; Port Gibson; Fayette; Sumner Tunica; Woodville
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	Medical Clinics	Medical Services	Clarksdale; Hazlehurst; Crystal Springs; Port Gibson; Tunica; Woodville
Coahoma; Claiborne; Copiah	Coahoma Community College; Claiborne County VoTech Complex; MS Job Corp	GED; Trade classes	Clarksdale; Port Gibson; Crystal Springs
Copiah; Claiborne	Cooperative Extension	Nutrition; homemaker services; parenting material	Gallman; Port Gibson
Coahoma; Copiah	Bethesda Counseling Service; Dr. Hill Chance	Counseling	Clarksdale; Hazlehurst
Copiah	Copiah County Ministerial Association	Parenting classes; financial assistance	Hazlehurst

Counties Served	Agency Name	Services Provided	Location
Copiah; Claiborne	AFJC Community Action	Utility bill assistance; in-service training; emergency medications	Hazlehurst; Port Gibson
Copiah	SOS Pantry	Food distribution	Crystal Springs
Copiah; Tunica	Parks and Recreation	Parks; pool; sports	Crystal Springs; Tunica
Copiah	Crystal Springs Junior Auxiliary	Swim lessons; clothes; school supplies	Crystal Springs
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	County Hospital	Medical services	Clarksdale; Hazlehurst; Port Gibson; Fayette; Tunica; Centreville
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	Day Care Centers	Day care assistance 0-5	Clarksdale; Friars Point; Jonestown; Lula; Lyon; Hazlehurst; Crystal Springs; Fayette; Wesson; Alcorn State; Port Gibson: Fayette; Tunica; Robinsonville; Centreville; Woodville
Coahoma; Copiah; Claiborne; Jefferson; Tunica; Wilkinson	Head Start Centers	Head Start 3-5	Clarksdale; Hazlehurst; Crystal Springs; Port Gibson; Fayette; Tunica; Centreville; Woodville
Tunica	Region I Mental Health Center	Out-patient mental health treatment	Tunica
Wilkinson	Wilk-Amite Baptist Association	Food, clothing, utility and prescription drug assistance	

To assist in the identification and coordination of services for participant families, an advisory team is being developed in each of the identified counties. It is expected that this team will address the availability of resources, as well as ways to avoid duplication of services. Healthy Families America, the selected home visiting model, supports home visitors in identifying family needs and bridging the connection to existing resources. The county advisory teams will act as a source of knowledge for family support workers as they assist families in accessing and coordinating services and available support. Additionally, it is expected that members will serve as referral sources.

Overall, resources for residents are limited in scope. On the other hand, it is possible that available resources are not being accessed because residents are either unaware that they exist or

the challenges in accessing them may overwhelm already stressed families. HHM will assist families in identifying their needs and making them aware of the services that are available so that they may fully utilize them.

Coordination of services for families is an essential component of the Healthy Homes Mississippi program. Moreover, collaboration among community partners in this effort will further the State's goal of developing an integrated system of early childhood care. In 2008, the Governor of Mississippi established a State Early Childhood Advisory Council (SECAC) which is charged with, "developing recommendations for increasing access to high quality state and federal early childhood care and education programs for all children- including those in underrepresented and special populations- and conducting a periodic state needs assessment of the quality and availability of programs. The Council also addresses recommendations for the development of a comprehensive early childhood data system, a statewide professional development system, and research-based early learning standards," (National Governor's Association, Center for Best Practices, 2010.)

The SECAC has agreed to serve as the statewide advisory board for Healthy Homes Mississippi. It is anticipated that this relationship will facilitate the integration of HHM into a statewide coordinated system of care at both the community and the state level. (A discussion of local advisory boards is in Section IV). HHM will benefit from this alliance as it taps into an existing structure of organizations and agencies that is tasked with improving the early childhood experiences of some of our most vulnerable citizens.

At-Risk Counties not Selected for Implementation

Counties that were identified as being at risk in the initial needs assessment that are not targeted for implementation of the home visiting program due to funding limitations on available FY2011 funding include: Chickasaw, Holmes, Humphreys, Issaquena, Jasper, Kemper, Noxubee, Sunflower and Tallahatchie. Healthy Homes Mississippi hopes to expand home visiting services to more of these areas as FY2012 funds are made available.

How Home Visiting fits with SECAC

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As recent as the summer of 2010, Parents as Teachers had a site in Copiah County. Funding was administered through the County Board of Supervisors. According to a member of the Board, the program was discontinued amid questions from the Board about the program's operations. The member could not provide additional information about the program's closure and current contact information for those directly involved with implementation of the program was not available.

Since the provision of in-home services is limited, the state does not have mechanisms for screening, identifying and referring families to home visiting programs in either of the counties.

Section II. Program Logic Model

Healthy Homes Mississippi

State Goals & Objectives: (1) Women and families see improvement in risk factors. (2) Pregnant women obtain services and counseling that result in improved prenatal and child health. (3) Parents are more attuned to appropriate care of their children. (4) Infants and small children experience improved social, emotional and cognitive development. (5) Families experience improved maternal, infant and early childhood development and parent-child relationships.

Program Population: The Healthy Homes Mississippi (HHM) program will serve low income families with small children and low education levels and a need for support services. **Assumptions:** Many research studies have been conducted on the effectiveness of Healthy Families America and Partners for a Healthy Baby. Both have been proven to reduce the rates of child maltreatment, increase positive birth outcomes and use of routine medical care and positive parenting practices. Additionally, research clearly demonstrates the effectiveness of comprehensive home visiting programs in supporting families.

LOGIC MODEL

Inputs / Resources / Elements *(Where HHM is Investing)*	Activities / Outputs *(HHM's Guiding Principles and Efforts)*	Outcomes *(Short and Long Term)*

Inputs
• Family Risks and Protective Factors
• Family Demographics
• Low income families with small children and low education levels that need support services
 	
Resources
• Program Manager and Program Supervisor
• Data Analyst
• Field Supervisors and Support Workers
• Training and Curriculum Materials
• Hand-out Materials for Families
• Electronics for Implementation Staff
• Food for Meetings
• Interagency Collaborations including:
  • Early Head Start
  • County Health Departments
  • DV Shelters
  • Injury and SA Programs
  • Mental Health
  • Other available social service programs
 	
Elements
• Enroll families prenatally or with child at 0 – 3 months
• Voluntary
• Standardized Assessments
• Routine Home Visits
• Focus is on Child Development, Parent-Child Interaction and Parent Support
• Link to Community Services
• Broad and Intensive Training
• Regular supervision
	Parenting
	• Parenting Curriculum—Partners for a Healthy Baby
	• Role modeling & Support groups
	• Developmental Expectations (ASQ)
	
	Child Development
	• Developmental materials and activities
	• Screening/Referral for Developmental Delays
	
	Self Sufficiency
	• Skill Building
	• Family Empowerment
	• Enrollment into education, employment, housing, etc. services
	• Linkages to Mental Health and Substance Abuse Services
	• Provide assistance to help parents navigate enrollment processes for support programs
	
	Health
	• Developmental Screens/ Referrals
	• Prenatal Care
	• Nutrition Education
	• Linkage to health care
	• Education on Home and Child Safety
	
	Local and State HV Structures
	• Collaborate between State Agencies
	• Contract Management
	• Planning, Marketing, and Materials
	• Technical Assistance
	• CQI
	• Local Community Resources
		Short Term Outcomes
		Parenting
		• Provide a safe home environment
		• Positive Parent-Child Interaction
		• Increased Parenting Knowledge, Skills
		
		Child Development
		• Positive Parent-Child Interaction
		• Enrollment in Quality Child Care
		• Early Identification of Developmental Delay
		
		Self Sufficiency
		• Reduced Parental Stress, Maternal Depression, and Social Isolation
		• Improved Education level, Employment, and Housing
		
		Health
		• Early Identification/Treatment of Develop Delay
		• Healthy birth weight
		• Complete Well-care Visits & Immunizations
		• Increased Child Safety
		
		Local and State HV Structures
		• Increased Coordination and Referrals for Other Community Resources and Supports
		
		Long Term Outcomes
		• Improved Maternal and Newborn Health
		• Reduced Child Injuries, Abuse, Neglect and Maltreatment.
		• Improved School Readiness and Achievement
		• Reduced Domestic Violence
		• Increased Family Economic Self-Sufficiency

Section III: Home Visiting Model

Home Visiting Model and Curriculum

Mississippi will implement the Healthy Family America (HFA) home visiting program utilizing the Partners for a Health Baby (PHB) curriculum. The HFA model is designed for pregnant women or mothers who have recently given birth and have children less than three months of age. The overall goals of HFA are:

- To systematically reach out to parents to offer resources and support;
- To cultivate the growth of nurturing, responsive, parent-child relationships;
- To promote healthy childhood growth and development; and
- To build the foundations for strong family functioning.

The general objectives of HFA address many of the challenges facing residents in the selected counties. The strategy to promote healthy childhood growth and development will target the high premature birth rates in Claiborne and Copiah counties, as well as the high infant mortality and low birth weights births that occur in Jefferson and Copiah counties. Claiborne, Copiah, Jefferson and Wilkinson counties all have identified the lack of mental and medical health services as hindrances to family well-being. One of the core components of HFA is the establishment of a medical home, which should help providers identify health needs, which is the first step in linking individuals to services and access to care. The model also works within the family structure to help parents identify their own needs which increases family functioning and well-being. Teen pregnancy, which is strongly correlated with teens not completing high school, is significant in each of these counties. In building the foundations for strong family functioning, pregnant or parenting teens that have not completed high school can be linked to services that would decrease dropout rates and increase the likelihood of gainful employment.

As part of the home visiting model selection process, the Mississippi home visiting assessment team contacted HFA developers secured information about the basic elements of the program and its implementation. Relevant topics examined included: structure and content of the program; requirements for becoming an HFA affiliated site; staffing and resource needs; other considerations for program implementation; training opportunities; and technical assistance availability.

Given that HFA does not include a curriculum, the team also solicited the developers' recommendations for curricula that best suit model delivery or curricula that are currently being used by affiliates. HFA personnel identified two primary curricula used by sites adopting their model: Growing Great Kids and Partners for a Healthy Baby. A third curriculum, the Nurturing Parent Program, has been approved at three HFA sites; however, it was not given consideration for Mississippi because the teen parent and prenatal components of Nurturing Parent are designed for group sessions only.

The team reviewed information available for each curriculum with special emphasis given to the target population and program content and selected Partners for a Healthy Baby as the

educational component for Healthy Homes Mississippi. This curriculum was deemed appropriate for several reasons. 1) PHB addresses child health and development within the context of the needs of the family unit as a whole. The curriculum is divided into five components which cover different stages of child development: prenatal; birth to six months; 7-12 months; 13-18 months; and 19-36 months. 2) Evaluation of programs implementing PHB have reported evidence of improved mother/child well-being in areas that are of concern in our target counties including: decreased incidence of low birth weight and small for gestational age babies; fewer repeat pregnancies; reduced rates of physical abuse and neglect, increased timely immunization and enrollment in a medical home; greater likelihood mothers will read to their children; improved child development and increased maternal responsiveness of adolescent mothers. 3) PHB includes handouts that are culturally diverse, summarize critical points and allow the family support worker to select ones that are most appropriate for the family involved. Finally, each unit of the curriculum includes guides to facilitate the home visit process and contribute to fidelity of model delivery.

At some point both HFA and PHB have operated in the state, but their implementation was isolated and of limited duration. Attempts were made to contact the last known individuals affiliated with HFA, but it was learned that the program site is not in operation and the individuals previously associated with its implementation are no longer employed with the organization. Mississippi Action for Progress (MAP) operates an Early Head Start Program that utilizes PHB. MAP personnel stated that of their twenty-county Head Start sites, only two of them incorporate home-visiting. The two sites offering the program were recently acquired from another organization and MAP supervisory staff have not yet attended the required training. The program operates in two counties in the northern portion of the state.

The two agencies charged with developing and implementing the home visiting program for Mississippi have not had prior experience with implementing either HFA or PHB. However, based on what is known of the history of these programs in the state, it is not anticipated that the issues that led to their discontinuance will impact current efforts. MDHS and MSDH both are state agencies that have implemented and operated family service programs on a broad and consistent basis. Although home visiting programs, as defined in this initiative, have not been instituted on a large scale, these agencies have the infrastructure to offer ongoing support and operation of such programs. In addition, both currently provide a range of services for families that would potentially be eligible for this program, and consequently have the community contacts that are vital for developing a community-level, comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships.

Model Fidelity and Quality Assurance

Healthy Homes Mississippi will develop a quality assurance plan to ensure that HFA and PHB are implemented with fidelity; that program staff have the feedback necessary to effectively and efficiently carry out their job responsibilities; and that families participating in HHM receive quality services. Data for gauging quality assurance will be extracted from the Family Wise data collection system (discussed in detail below). The quality assurance plan, coupled with

guidelines from HFA, will serve to ensure that the model is implemented with fidelity. The essence of the plan's policies, responsibilities, and requirements are outlined below:

- The Data Analyst will conduct daily data checks to monitor the data in the Family Wise system to identify and resolve any data entry issues.
- The Operations Supervisor, through the information entered into Family Wise, will work with the Family Support Supervisors to ensure that the model components are being followed and implemented as specified.
- The Operations Supervisor will monitor work plans to ensure the families are receiving services as dictated by the model. The Operations Supervisor also will follow up with the Family Support Supervisor to discuss concerns related to implementation and delivery of the program and how these issues may be resolved.
- The Operations Supervisor will establish a comprehensive audit program to monitor and verify the management of the program through:
    - Scheduled quarterly audits to examine model requirements; time frames will be posted to all applicable program personnel.
    - Scheduled non-routine audits (unannounced) to focus on a particular component of the model, e.g. all survey data for a particular federal benchmark.
    - Compiled results with which to debrief Division of Early Childhood Care and Development (DECCD) Directors.
- The Family Support Supervisor will assist the Operations Supervisor in conducting quarterly and non-routine audits; the Family Support Supervisor, at the discretion of the Operations Supervisor, may conduct these audits. If the Family Support Supervisor is required to conduct an audit in the absence of the Operations Supervisor, the Family Support Supervisor will keep audit results confidential and debrief the Operations Supervisor when required.
- The quality assurance plan will serve as a tool to assist in program planning and evaluation; it will be reviewed annually and amended as necessary.

The Family Wise Database, which has played a key role in supporting Healthy Families sites since 1996, will be the primary tool for collecting information about clients and client services. The database provides solutions for case management, evaluation, accreditation and reporting with each part supporting fidelity of the Healthy Families model. Since its inception, this database has evolved to reflect developments and changes in the Healthy Families model. The database supports model fidelity through a number of elements:

- Input forms that are tailored to support all collection plan inputs of Healthy Homes Mississippi (e.g., North Carolina Family Assessment Scale surveys) necessary to document of all federal benchmark requirements.
- The system enables users to capture information on both clients and client services.
- Each federal benchmark can be studied from inputs received—reports are produced which provide real time analysis. Model elements can be assessed in both service delivery and quality.
- The system captures critical service information; the database ensures that needed model reporting is timely, reliable and accurate.
- The system is very secure and is routinely tested to ensure data are not compromised.

Other requirements of the developer serve as checks to ensure model fidelity. Although HFA is to be tailored to individual family needs, it includes critical elements of both service initiation and service content. HFA affiliates must:

- Initiate services prenatally or at birth.
- Use a standardized assessment tool to identify families who are most in need of services.
- Offer services voluntarily and use positive outreach efforts to build family trust.

Service content should be:

- intensive (i.e. at least once a week) with well-defined criteria for increasing or decreasing frequency of service and over the long-term;
- culturally competent in regard to staff and materials used;
- focus on supporting the parent as well as supporting parent-child interaction and child development;
- able to link families to a medical provider to assure optimal health and development (e.g. timely immunizations, well-child care, etc.) and other services as needed; and
- provided by staff with limited caseloads (i.e., for many communities no more than 15 families per family support worker on the most intense service level).

Each of the data points to assess these elements is available through Family Wise and will be used to determine the extent to which the core components as required by HFA have been implemented.

Additionally, HFA requires sites that become formally affiliated with the initiative to complete an accreditation process which includes a self-assessment by the applicant organization and a site visit by a peer review team. These efforts ensure that programs are committed to the twelve critical elements of the program and implement them with fidelity. Technical assistance for completing accreditation is available through HFA quality assurance staff and will be requested by HHM as needed.

The HHM program is a new program for Mississippi. DECCD has taken all requirements, regulations, laws and mandates into consideration when developing this program. DECCD is prepared to identify opportunities for improvement as implementation begins. Nonetheless, we do not anticipate any challenges to maintaining fidelity to the model selected.

Implementation Challenges

The model and curriculum we have selected will present us with challenges when we begin implementation, but none are considered insurmountable. One of the issues we expect to face is enrolling participants within the specified time frames; parents are expected to be recruited and enrolled either prenatally or no later than when the child is three months old. For pregnant women, we want to enroll them as early as possible as one of the goals of HHM is that women enter into care by their second trimester. The challenge will be greater for teen moms, who often are in denial of their pregnancies or try to hide them from their families. We will work with community partners to

develop a plan to identify potential participants and to refer them for screening as quickly as possible. For example, from our discussions with local Head Start programs we have considered the possibility of assessing parents they have wait listed for Early Head Start HHM eligibility. We will also use community listening sessions to determine how to best recruit and enroll pregnant teens.

A second issue we will have to confront is the engagement of fathers in the program. Two of the outcomes of HHM address involvement of fathers in the lives of their children. Many of our participants will not have the father in the home, and others may not have a positive relationship with the father. Due to the sensitive nature of this issue, it will be dealt with on a case by case basis.

We acknowledge that resources in these communities are limited, and staff will have challenges in meeting the needs of families when appropriate services are not available, or are very limited. In an effort to assist the family unit in healthy functioning, DECCD will enhance the HFA model to include marriage and family therapy (MFT) services in the homes of all participating families. DECCD will contract with an agency to offer MFT services at no cost to families. HFA views this as an enhancement to their model and requires no special consideration of this service. DECCD feels that this unique approach to providing mental health services will enable more families to receive the support they need. It should be noted that the provider shortage issue is not limited to these particular counties. Mississippi faces statewide shortages in a number of health care areas; the concern becomes more acute for uninsured/underinsured clients.

Finally, transportation may be a barrier to clients' access to services, particularly for those residing in rural areas. Program staff will work with the families and community partners to produce the best possible solutions utilizing the resources that are available.

Section IV: Program Implementation

Community Engagement

Healthy Homes Mississippi will be developed and implemented with consideration and advisement of community stakeholders. To further the goal of community buy-in and commitment to the program, input will be sought in the early stages of program development and implementation and as the program expands. The community involvement plan calls for various levels of engagement: a community level advisory team, a collaborative of service providers and listening sessions with community residents.

Community Advisory Team

The community level advisory team will include leaders, professionals and residents that are local to the community. The general purpose of the advisory group is to help further the goals and objectives of the program. Since this is a new initiative, it is expected that the advisory group will provide suggestions that will aid in developing, sustaining and growing the home visiting program. The advisory group will include (but will not be limited to) representatives from the following areas:

- Community/civic leaders
- Faith community
- Business leaders
- Consumer representatives (families)
- Head Start representative
- Mental health and alcohol treatment program
- Public assistance workers
- Domestic violence victim advocates
- Government agencies (health department, children and family services)
- Education (local schools)

The make-up of the advisory team will be evaluated as the program evolves and amended as needed. Members will be selected through a "snowballing" process. In other words, we will ask people (initially our primary community contacts) to identity community leaders or those whose opinions are valued in the community for each of the specific areas. People who are mentioned frequently will be asked to serve on the advisory team. Recommendations for member types other than the ones we have identified will be considered.

Collaborative of Service Providers

Community input also will be solicited from agencies and/or organizations that provide services to the target demographic of HFA, i.e., pregnant women and/or parenting women with children less than three months old, or that would be a potential referral source for client services. Providers will be able to identify local resources as well as existing linkages and partnerships. Convening a group of this nature will assist HHM in coordinating services and avoiding

duplication of efforts. Members for this team will be identified through a similar snowballing or recommendation process.

Community Listening Sessions

Given the unique perspective of those who will be actively engaged in the program, prior to finalizing the recruitment plan, we will hold a listening session in each community designed exclusively for eliciting feedback from client level participants. The utility of continuing this or a similar activity will be determined as the implementation process develops.

Community Contacts

The initial process of community engagement has begun and contacts have been made with some providers; subsequent meetings have been scheduled. A brief description of the current stage of community involvement follows.

Southwestern Counties

HHM met on June 8, 2011 at the Jefferson County Division of Family and Children Services (DFCS) office with the Regional Director for Region V of DFCS, the supervisor for Jefferson County and the Early Head Start Director for AJFC in Jefferson County. We also had a meeting on June 15, 2011 at the Claiborne County DFCS office with the DFCS County Supervisor, AJFC Community Action Agency representative for Claiborne County and a representative from Mississippi Action for Progress Head Start Agency. During our Copiah County visit we garnered support for the program and solidified a commitment from several agency representatives. The local Head Start/Early Head Start agency (Friends of Children of Mississippi, Inc.) agreed to refer parents that are on their waiting list to HHM. The Copiah County Division of Family and Children Services (DFCS) has also committed to referring eligible families to our program. Agency representatives were able to identify other community members that will be useful in local program promotion. We met in Wilkinson County on June 28, 2011 with area social work supervisor, case managers, and the Director of Domestic Violence Programs.

Northwestern Counties

Initial meetings for Coahoma and Tunica counties will be scheduled upon confirmation of approved funding. HHM expects local agencies and Head Start/Early Head Start to refer eligible parents. As with the Southwestern Counties, we will engage through local community leadership and contacts that have already been established.

Policies, Procedures and Staff Training

A policy and procedures manual is currently in development and will include guidelines for employment with the Mississippi Department of Human Services, as well as guidelines specific to the Healthy Homes Mississippi program. Standards will focus on implementing the home visiting model with fidelity; continuous quality improvement strategies and meeting legislative mandated benchmarks. Home visiting staff will receive training and professional development from both the model developers and local MDHS/HHM administrators. The initial training will

take place upon hiring; opportunities for professional development will continue throughout employment.

Both HFA and PHB require affiliates to undergo training provided through their national offices prior to implementing their model or curriculum. HFA provides on-site and web based training. Core training, which instructs staff in their specific roles, is required for all direct service staff and their supervisors/program managers within six months of being hired. Core training is conducted in person at the affiliate site. Specialized core training is available for staff whose primary responsibility is to conduct the initial assessments of families entering the program. A module for advanced supervisor training, which focuses on supervisory and management skills, is expected to be available at the end of 2012. The HFA Learning Center website helps staff and supervisors track successful course completion. Additionally, supervisors receive notice when staff are nearing due dates to ensure timely receipt as required by HFA best practice standards.
Home visitation staff also will have access to twelve online self-paced modules that provide 35 hours of additional training on topics designed to assist them in their duties (e.g., keeping babies healthy and safe; fostering infant and child development; addressing domestic violence; preventing child abuse). The online training schedule will be determined by HHM supervisory staff.

The next available training session for PHB is April 10-13, 2012. Home visiting administrative staff will attend this session. They, in turn, will train family support workers (May 2012).

One component of the state level instruction for family support workers and supervisors will be specific to the essential components of family assessment and home visitation (i.e. identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, teaching parent-child interaction, managing crisis situations, etc.). Given the high level of impoverishment in the program counties, home visitation staff also will undergo intensive training relative to working with families in poverty. We will utilize Bridges out of Poverty and A Framework for Understanding Poverty. Bridges out of Poverty is an approach designed to assist stakeholders/organizations in addressing poverty, with the goals of preventing, reducing and/or eliminating it altogether. Both of these works will provide staff with a better understanding or the challenges and strengths of their clients, which is crucial given that in three of the four counties in which HHM will be implemented, approximately one out of three residents live at the poverty level.

As family support workers begin to see clients, professional development will focus on the home visiting process and staff interactions with the families, e.g., developing realistic and effective plans for families; working effectively with families to achieve objectives; addressing families that do not appear to be making adequate progress, etc.

Other topics for professional development will be determined by the quality improvement data and solicited from home visiting staff and scheduled as needed. State level training will be the responsibility of MDHS and HHM administrative staff.

Recruitment, Hiring and Retaining Staff

Since program personnel will be employees of MDHS, existing standards and guidelines will be followed for recruitment and hiring of project staff. We anticipate recruiting family support workers and supervisors beginning January 1, 2012 and having staff in place by February 1, 2012. PHB offers its next training session April 10-13, 2012. All materials for implementing the program will be obtained at the training sessions. (See Table 3 for proposed hiring and training schedule.) Administrative staff and the data analyst positions already have been filled.

Table 3. HHM Hiring and Training Schedule		
Month / Year	Activity	Responsible Party
November 2011	Posting of job and interviewing and hiring for home visiting (HV) staff and supervisor positions	MDHS-HHM administrative staff
January 2012	First day for all HV staff	
January 2012	Request bids for MFT services; training for all HV staff to include :MDHS orientation, Healthy Families America, FamilyWise, Bridges Out of Poverty; A Framework for Understanding Poverty	MDHS-HHM administrative staff; HFA Technical Assistance staff
January 2012	HV administrative staff attends Partners for Healthy Babies training	PHB Training Staff
January 2012	HV Family Support workers receive Partners for Healthy Babies training	HHM administrative staff
February 2012	HV staff works locally to promote Healthy Homes Mississippi and recruit families	Family support workers and supervisors
March 2012	HV staff, including MFTs, begins to see families	

The success of home visiting programs is largely dependent on relationships established between the family support worker and the client. Consequently, it is important that programs maintain their staff so that rapport and continuity can be established and maintained. Retention of home visiting staff is essential. Home visitation programs tend to be labor intensive and special attention has to be given to support staff, prevent burnout and reduce turnover. Efforts to retain HHM staff will focus on:

- proper training (program content and service delivery);
- regularly scheduled professional development;
- intensive supervision (group and individual);
- recognition of staff effort; and
- feedback offered through continuous quality improvement plan.

Providing home visiting services can be very stressful for family support workers, thus, they will be advised about typical reactions and symptoms of stress. Mental health professionals will

conduct monthly stress evaluations of the family support workers. Trustworthy working relationships with these mental health professionals will be ongoing according to the level of stress indicated in the evaluation. In order to provide continuous psychological support we will provide two staff retreats per year. It is our hope that turnover of staff will be low as a result of providing these mental health services.

During the initial stages of the program, supervisors will directly observe family support workers interaction with their clients at least once a week, until the supervisor has seen the worker with each of the clients. These visits will examine progress with the individual families and give the families an opportunity to address any concerns. Monthly meetings between the supervisors and family support workers will allow for discussion of individual accomplishments, goals and challenges. Peer feedback will also be provided as a means of support for the workers.

Identifying, Recruiting and Retaining Participants

We anticipate working with community partners to develop a plan for the identification and recruitment of eligible eligible families. Although the recruitment plan has not yet been finalized, it generally will flow in the following manner:

1. Initial identification of potential participants by community partners (pregnant women or women with children less than three months old);
2. Initial screening of potential participants to identify priority families (community partner);
3. Solicit permission of participant to be contacted by HV staff (official referral by community partner);
4. Contact of referral and further screening and assessment of participant by HV staff;
5. If clients are eligible and willing to participate they will be recruited into the program and assigned to a family support worker; if they are not eligible or are not interested in HHM and have identified unmet needs, they will be referred to appropriate agency/organization;
6. Self-referrals will be assessed and screened in the same manner as community partner referrals;
7. Family will receive home visiting services until child is age 3.

Steps 1-3 are designed to not increase the burden of work of our community partners. They will be aware of the initial criteria and priority family types and make the decision to refer based on their knowledge of the client. It is up to the home visiting staff to conduct the screening and assessment to determine if the referral is appropriate for the program. For example, clients seeking Head Start services would have undergone an application process that likely yielded enough information on which a referral could be made. The same goes for providers of prenatal care to un/under-insured women or social service providers and school counselors.

The recruitment process will be reviewed each month to determine its effectiveness. As we engage more with participants and expand our network of community partners, this process is likely to become refined and adapted to fit the needs of each community. It is anticipated that as

the program becomes more established in the community, we will receive self-referrals. There will be screened and assessed the same as community partner referrals.

At maximum caseload, HHM will serve 300 families in six counties. Two family support workers each will be assigned to Jefferson and Wilkinson counties (60 families) and three family support workers will see families from Copiah and Claiborne counties (90 families). Five family support workers each will be assigned to Coahoma and Tunica counties (150 families). Family support workers will work under the direct supervision of two program supervisors. Each family support worker will have a maximum caseload of 15 families and each supervisor will have responsibility for no more than 4 family support workers. Given what we know about each of the communities, we anticipate being at full caseload 6-12 months after the program has been initiated, or no later than January 2012.

Home visiting programs are service intensive and as such, require a commitment of time and effort from the client. For a program of this nature, attrition likely will be due to families either missing scheduled visits or families leaving the program entirely. Both of these factors can be minimized with proper training of family support workers and effective program management. Plans to handle these issues will include strategies to:

- develop strong rapport between the family support worker and participant families;
- explain the level of client commitment required to potential participants prior to enrollment and encourage continued commitment once enrolled;
- limit the caseload of family support workers so they have some flexibility to reschedule appointments;
- actively contact parents who miss scheduled appointments or otherwise indicate a lack of commitment to the program;
- offer incentives to participation (crib and bedding; car seat; basic care necessities (nail clippers, thermometer, nasal aspirator, etc.; basic feeding necessities (bottles, spoons, bowls, etc.); diapers; clothing; and bouncer seat. These items will be offered to the families as needed; if parents accept them, they must not seek to obtain them at any other community organizations/resources. The family support workers will work with families in assisting them with identifying their needs.

We also will use information obtained from the listening sessions with community members to identify potential barriers to full participation and to develop strategies to keep clients actively engaged in the program.

Coordinating Community Services

As we work with community partners, we will identify existing linkages and partnerships. We will build upon these to develop a resource network of providers in the areas of health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services. The communities that we are targeting are relatively small and services providers are limited; therefore, making connections with them will not pose a major challenge. Our goal is for home visiting staff to develop relationships with each provider so that if/when referrals are made, the client will have less difficulty navigating the process to receive services.

The ultimate goal is to convene a service provider working group consisting of representatives from each of the aforementioned areas. The purpose of this group would be to identify existing services (and changes), gaps in services and to develop effective ways of coordinating and streamlining services for clients.

Data Collection and Management

HHW will utilize the Family Wise data management system, which is designed specifically to collect data for home visiting programs, to assist in the collection of quantitative data. The system captures information on clients, client services and model elements that allow for assessment of service delivery and quality assurance. The system enables administration, research, evaluation, and ad hoc reporting, as well as connection to administrators and evaluators. It enhances work flow by capturing all of the critical service information and ensuring that necessary reporting is timely, reliable, and accurate. The system enables efficient management of data in a manner that is both effective and secure. Family Wise also has the capability necessary to store large amounts of information on a long term basis and the capacity to expand to include data that are specific to the HHM program.

Client and client services data are entered by the family support worker. The data analyst is responsible for monitoring and managing data input. (A more detailed description of data management is discussed in the CQI plan.)

Program Assurances

The Healthy Homes Mississippi home visiting program provides the following assurances:

- the State home visiting program is designed to result in participant outcomes noted in the legislation;

- individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments;

- services will be provided on a voluntary basis;

- the State will comply with the Maintenance of Effort Requirement; and

- priority will be given to families that:

    - Have low incomes;
    - Are pregnant women who have not attained age 21;
    - Have a history of child abuse or neglect or have had interactions with child welfare services;
    - Have a history of substance abuse or need substance abuse treatment;
    - Are users of tobacco products in the home;
    - Have, or have children with low student achievement;

- Have children with developmental delays or disabilities;
- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Because Mississippi does not have a history of home visiting programs at the state level, the plans for program development and implementation initially will be designed to accomplish all requirements of funders and home visiting program model developers. Mississippi will not attempt to align existing home visiting program policies and goals with these requirements, however, and can therefore ensure compliance at every level.

Section V: Plan for Meeting Legislatively-Mandated Benchmarks

- **Demographic and service-utilization data.**
  - In the "Strong Families Through Home Visitation" (our needs assessment) studies were conducted on county and state demographics from organizations such as Mississippi Department of Human Services (MDHS), MDHS Division of Youth Services, Division of Medicaid, Department of Employment Security, Department of Mental Health and state Head Start Programs. These demographic data sources included:
    - child and maternal health data including total births by mother's county of residence, teen births, infant mortality rate, premature births and low birth weight births
    - Domestic violence services
    - juvenile justice referrals and community resource and needs assessments
    - substance abuse counseling and treatment service' substance abuse data
    - State Head Start and MDHS Office of Youth community needs assessments
  - Demographic and service-utilization data will be collected as part of the enrollment process for HHM.

Demographic Data	Service Utilization
Family social and economic indicators as identified in the Life Skills Progression Scale. This includes the employment status as well as the income of the family	Participation in service resources that directly support improvement in employment and income for the family
Family rate of participation in HHM	How man visits do enrollees actually achieve versus visits available
Gender of participants	Participants enrolled
Gender of participants	participants enrolled
Race / Ethnicity of participants	participants enrolled
Family educational indicators such as those pursuing a GED, college, or trade school	Participants in service resources that directly contribute to improvement in educational status

- **Benchmark data for data driven CQI.** Section 7 goes into significant detail about CQI and how Benchmark Data will be utilized
- **Data Safety / and compliance with HIPAA, FERBA, and IRB/Human Subjects.** Data safety and protection is a top priority for HHM, its entire staff, and the data management system that will house the results of benchmark results that are driven through the various questionnaires that support HHM's mission. HHM will ensure that families that are served are protected through a staff that is proficient in the execution of oversight with regard to all regulations that protect individual privacy--including HIPPA and FERPA as well as state, Federal, and IRB/human subject protections. HHM staff will be trained to identify mandatory reporting requirements for all cases involving possible maltreatment/neglect. As outlined in section 3, there are several layers of oversight to ensure the highest standard of safety is carried out; Family Support Supervisors will consistently oversee the activities and reporting actions of the Family Support Workers. Management and safety of all documentation will be regularly audited to ensure quality oversight of all program requirements which includes safety of enrolled participants' personal information.

- **Rationale for selecting measurement tools and reliability and validity of measurement tools.**
    - Many of the Measurements for Constructs were mandated in the SIR. In such cases, HHM complied with the SIR.
    - Various data collection tools were assessed; many factors were considered including but not limited to time to gather (the data), validity and reliability, and existing measurements that were accepted by collection tools that HHM will utilize such as: the Life Skills Progression Scale, Ages and Stages Questionnaire, and Familywise Database data points.
    - Finally, we also considered data which is already captured and measured--such as data provided in our initial needs assessment. This assessment provided concepts and measures for data in Appendix A.
- **Describe any possible challenges with data.**
    - Possibly our greatest challenge will be that the state of Mississippi has never had a Home Visiting Program. Consequently, many of the challenges--data and otherwise--will likely be a result of limited exposure in the Home Visiting arena. What HHM does have is some of the very best leaders at the state and local level; these leaders are intimately familiar with their counties and state's constraints as it relates to data challenges. Additionally, the database that will be utilized is customized to fit every single Benchmark requirement of the Maternal, Infant and Early Childhood Home Visiting Program. With the experience of Mississippi's finest early childhood care and development leaders at the helm and the continued support and technical assistance from the professional staff at the Federal level, HHM expects to meet any possible challenges to data with timeliness, appropriateness and success.

Benchmark I. Improved Maternal and Newborn Health						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Prenatal care **[National Committee for Quality Assurance - Health Care Accreditation Organization]**	Percent of **mothers** who receive prenatal care (Outcome)	Mothers who had a prenatal visit in the first trimester or within 42 days of enrollment/ # enrolled mothers	Increase in the percentage of mothers who utilize prenatal care from baseline year 1 to year 3	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Parental use of alcohol, tobacco, or illicit drugs	Percent of **parents** that use alcohol, tobacco or illicit drugs (Input)	# enrolled parents who self-report use of alcohol, tobacco, or illicit drugs / # enrolled parents	Decrease in the percentage of parents who use alcohol, tobacco or illicit drugs from base line year 1 to year 3	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Preconception care	Percent of **mothers** who receive preconception care by means of personal health & family planning (Outcome)	# enrolled mothers who utilize preconception care / # enrolled mothers	Increase in the percentage of mothers who utilize prenatal care from baseline year 1 to year 3	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Inter-birth intervals	Average inter-birth interval months for **mothers** (Outcome)	# of inter-birth interval months / # enrolled mothers	Increase in the average # inter-birth interval months for enrolled mothers from baseline year 1 to year 3	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark I. Improved Maternal and Newborn Health						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Screening for maternal depressive symptoms (For this construct, our population is any enrolled mother that we identify as having maternal depressive symptoms, and we are measuring how many in that population actually get help)	Percent of **mothers** with symptoms of maternal depression (Outcome)	# enrolled mothers who are identified as having maternal depression and have received appropriate treatment/ # enrolled mothers who are identified as having maternal depression	Decrease in the percentage of enrolled mothers who are identified as having maternal depression and have not received appropriate treatment from baseline year 1 to year 3	• Edinburgh Perinatal Depression Scale • Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Breastfeeding	Percentage of mothers who breastfeed their children from 0 to 6 months of age (Outcome)	# enrolled mothers who breastfeed their children from 0 to 6 months of age/# enrolled mothers who have children from 0 to 6 months of age	Increase in the percentage of enrolled mothers who breastfeed their children from 0 to 6 months of age	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Well-child visits	Percentage of **children** who receive the recommended well-child visits (Outcome) Healthy Families America National Standard	# enrolled children who received well-child visits / # enrolled children requiring well-child visits	Increase the percentage of attendance for well-child visits for enrolled children from baseline year 1 to year 3	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark I. Improved Maternal and Newborn Health						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Maternal and child health insurance status	Percentage of **mothers** who have health insurance (Outcome)	# enrolled mothers who have health insurance / # enrolled mothers	Increase the percentage of enrolled mothers with health insurance from baseline year 1 to year 3	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Maternal and child health insurance status	Percentage of **children** who have health insurance (Outcome)	# enrolled children who have health insurance / # enrolled children	Increase the percentage of enrolled children with health insurance from baseline year 1 to year 3	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Benchmark II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits						
Visits for children to the emergency department from all causes	Percentage of **children** who visit the emergency department (Outcome)	# enrolled children who visit the emergency department due to injury or ingestion / # enrolled children	Decrease the percentage of enrolled children who visit the emergency department from all causes from baseline year 1 to year 3	• Family Wise Web Database	Monthly/Participant report, medical record, emergency department patient records or hospital discharge systems	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Visits of mothers to the emergency department from all causes	Percentage of **mothers** who visit the emergency department (Outcome)	# enrolled mothers who visit the emergency department / # enrolled mothers	Decrease the percentage of enrolled mothers who visit the emergency department from all causes from baseline year 1 to year 3	• Family Wise Web Database	Monthly/Participant report, medical record, emergency department patient records or hospital discharge systems	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety	Percentage of **families** who receive information or training on injury prevention (Input)	# enrolled families who receive information or training on injury prevention / # enrolled families	Increase the percentage of enrolled families who receive information or training on injury prevention from baseline year 1 to year 3	• Partners for a Healthy Baby Curriculum • Family Wise Web Database	Ongoing/Direct measurement by the home visitors and/or agency providing information or training	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Incidence of child injuries requiring medical treatment	Percentage of **child** injuries that require medical treatment (Outcome)	# enrolled children with injuries requiring medical treatment at any facility / # enrolled children	Decrease in the percentage of child injuries requiring medical treatment from baseline year 1 to year 3	• Family Wise Web Database	Monthly/Participant report, medical record, emergency department patient records or hospital discharge systems	Monthly report to CQI Team/program workers/ community stakeholders showing accuracy & changes over time

Benchmark II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)	Percentage of **child** cases of suspected maltreatment (Outcome)	# cases of suspected enrolled child maltreatment / # enrolled children	Decrease in the percentage of child cases where maltreatment was suspected from baseline year 1 to year 3	• Family & Children's Services Admin Data • Family Wise Web Database	Monthly/Admin data from state agencies.	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Reported substantiated maltreatment (substantiated/ indicated/ alternative response victim) for children in the program	Percentage of **child** cases of substantiated maltreatment (Outcome)	# cases of substantiated enrolled child maltreatment / # enrolled children	Decrease in the percentage of child cases where maltreatment was substantiated from baseline year 1 to year 3	• Family & Children's Services Admin Data • Family Wise Web Database	Monthly/Admin data from state agencies.	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
First-time victims of maltreatment for children in the program	Percentage of **children** who are first-time victims of maltreatment (Outcome)	# enrolled children who are first-time victims of maltreatment / # enrolled children	Decrease in the percentage of children who are first-time victims of maltreatment from baseline year 1 to year 3	• Family & Children's Services Admin Data	Monthly/Admin data from state agencies.	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Note: Data will be reported overall and will also be broken down for each construct by age category (0-12 months, 13-36 months, and 37-84 months) and the type of maltreatment (neglect, physical abuse, sexual abuse, emotional maltreatment, and other). Database Security: A single point of access allows for an inherently more secure data store in Familywise Database. Datatude, Inc. utilizes the most advanced defenses against hackers, denial of service attacks, viruses and worms. The Datatude network and application servers rely on sound technology, meticulous updates, and regular outside audits and consultation to create a reliable, and reliably secure, network.						

Benchmark III. Improvement in School Readiness and Achievement						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child	Percent of **parents** who are support their children's learning and development (Outcome)	# enrolled parents who provide support for their children's learning and development / # enrolled parents	Increase in the percentage of parents who support for their children's learning and development from entry to the program and one year after enrollment	• Healthy Families Parenting Inventory • North Carolina Family Assessment Scale-General • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Parent knowledge of child development and of their child's developmental progress	Percent of **parents** who are knowledgeable about their child's development and developmental progress (Outcome)	# enrolled parents who are knowledgeable about their child's development and developmental progress / # enrolled parents	Increase in percentage of parents who are knowledgeable about their child's development and developmental progress from entry to the program and one year after enrollment	• Ages and Stages Questionnaire • Ages and Stages Questionnaire-Social & Emotional	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	Percent of **parents** who demonstrate appropriate parenting behavior and parent-child relationship (Outcome)	# enrolled parents who demonstrate appropriate parenting behavior and parent-child relationship / # enrolled parents	Increase in percentage of parents who demonstrate appropriate parenting behavior and parent-child relationship from entry to the program and one year after enrollment	• North Carolina Family Assessment Scale • Healthy Families Parenting Inventory • Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark III. Improvement in School Readiness and Achievement						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Parent emotional well-being or parenting stress	Percent of **parents** who demonstrate emotional well-being and appropriate parenting stress levels (Outcome)	# enrolled parents who demonstrate emotional well-being and appropriate parenting stress levels / # parents enrolled	Increase in the percentage of parents who demonstrate emotional well-being and appropriate parenting stress levels from entry to the program and one year after enrollment	• Healthy Families Parenting Inventory • Edinburgh Perinatal Depression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Child's communication, language and emergent literacy	Percent of **children** who demonstrate appropriate communication, language and emergent literacy (Outcome)	# enrolled children who demonstrate appropriate communication, language and emergent literacy / # enrolled children	Increase in the percentage of children who demonstrate appropriate communication, language and emergent literacy from entry to the program and one year after enrollment	• Ages and Stages Questionnaire • Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark III. Improvement in School Readiness and Achievement						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Child's general cognitive skills	Percent of **children** who demonstrate appropriate general cognitive skills (Outcome)	# enrolled children who demonstrate appropriate general cognitive skills / # enrolled children	Increase in the percentage of children who demonstrate appropriate general cognitive skills from entry to the program and one year after enrollment	• Ages and Stages Questionnaire • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Child's positive approaches to learning including attention	Percent of **children** who receive positive approaches to learning including attention (Outcome)	# enrolled children who who receive positive approaches to learning including attention / # enrolled children	Increase in the percentage of children who receive positive approaches to learning including attention from entry to the program and one year after enrollment	• Ages and Stages Questionnaire • Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Child's social behavior, emotion regulation, and emotional well-being	Percent of **children** who demonstrate appropriate social behavior, emotion regulation, and emotional well-being (Outcome)	# enrolled children who demonstrate appropriate social behavior, emotion regulation, and emotional well-being / # enrolled children	Increase in the percentage of children who demonstrate appropriate social behavior, emotion regulation, and emotional well-being from entry to the program and one year after enrollment	• Ages and Stages Questionnaire-Social & Emotional • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark III. Improvement in School Readiness and Achievement						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Child's physical health and development	Percent of **children** who exhibit appropriate physical health and development (Outcome)	# enrolled children who exhibit appropriate physical health and development / # enrolled children	Increase in the percentage of children who exhibit appropriate physical health and development from entry to the program and one year after enrollment	• Ages and Stages Questionnaire • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Benchmark IV. Domestic Violence						
Screening for domestic violence	Percent of **participants** who have been screened for domestic violence (Outcome)	# enrolled participants screened for domestic violence / # population served	Increase in the percentage of participants who have been screened for domestic violence from baseline year 1 to year 3	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries)	Percent of **family** referrals made for relevant domestic violence services (Outcome)	# enrolled families (who were identified for the presence of domestic violence) who have been referred for domestic violence services / # population served	Increase in the percentage of family referrals made for relevant domestic violence services from baseline year 1 to year 3	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Benchmark IV. Domestic Violence						
Construct	**Population/ Indicator**	**Operational Definition**	**Definition of Improvement**	**Source / Measurement Tool**	**Frequency / How data will be collected**	**Link to CQI**
Of families identified for the presence of domestic violence, number of families which a safety plan was completed.	For **families** identified with the presence of domestic violence, Percent of completed family safety plans (Outcome)	# enrolled families (who were identified for the presence of domestic violence) who have completed family safety plans / # population served	Increase in the percentage of completed family safety plans for families who were identified with the presence of domestic violence from baseline year 1 to year 3	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Benchmark V. Family Economic Self-Sufficiency						
Household income and benefits	Average amount of total income and benefits for participants who live in the home at least 4 nights a week and contribute to the support of the child or pregnant woman linked to the HV program (Outcome)	Total household income and benefits / # enrolled participants who live in the home at least 4 nights a week and contribute to the support of the child or pregnant woman linked to the HV program	Increase in the average amount of income and benefits for participants who live in the home at least 4 nights a week and contribute to the support of the child or pregnant woman linked to the HV program for the month of enrollment and the month one year post enrollment	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Construct	Population/ Indicator	Operational Definition	Definition of Improvement	Source / Measurement Tool	Frequency / How data will be collected	Link to CQI
Employment of adult members of the household	Average amount of # of paid hours worked plus unpaid hours devoted to care of an infant by participants (Outcome)	# paid hours worked plus unpaid hours devoted to care of an infant of participants/ # enrolled participants	Increase in the average amount of hours worked plus unpaid hours devoted to care of an infant by participants for the month of enrollment and the month one year post enrollment	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Education of adult members of the household (degree, training, and certificate programs completed)	Average # of degree, training, and certificate programs completed by **adults** in participating households (Outcome)	# completed degree, training, and certificate programs by adults in participating households / # enrolled adults in participating households	Increase in the average # completed degree, training, and certificate programs by adults in participating households for the month of enrollment and the month one year post enrollment	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Education of adult members of the household (hours spent in educational programs)	Average # of hours per month spent by each **adult** household member in educational programs (Outcome)	# of hours per month spent by each adult household member in educational programs / # enrolled adults in participating households	Increase in the average # of hours per month spent by each adult household member in educational programs for the month of enrollment and the month one year post enrollment	• Life Skills Progression Scale • Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Construct	Population/ Indicator	Operational Definition	Definition of Improvement	Source / Measurement Tool	Frequency / How data will be collected	Link to CQI
Health insurance status	Percent of **household members** who have health insurance insurance for the month of enrollment and the month one year post enrollment (Outcome)	# of household members who have health insurance / # enrolled household members	Increase the percentage of household members who have insurance for the month of enrollment and the month one year post enrollment	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Benchmark VI. Coordination and Referrals for Other Community Resources and Supports						
Number of families identified for necessary services	Percent of **Families** screened for need of necessary services (Outcome)	# of families screened / # enrolled participating families	Increase the percentage of families screened for need of necessary services for the month of enrollment and the month one year post enrollment	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Number of families that required services and received a referral to available community resources	Percent of **Families** identified as needing services who received those services (Outcome)	# of families referred who were identified with needs and whose receipt of services was verified / # referred families	Increase the percentage of families who receive necessary services for the month of enrollment and the month one year post enrollment	• Family Wise Web Database	At each home visit/Interviews and surveys with families or administrative data at individual and family level	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Construct	Population/ Indicator	Operational Definition	Definition of Improvement	Source / Measurement Tool	Frequency / How data will be collected	Link to CQI
MOUs: Number of Memoranda of Understanding or other formal agreements with other social services in the community	Total # of **social service agencies** with an MOU and/or regular communication (Outcome)	Total # of social service agencies with an MOU and/or regular communication	Increase the # of formal agreements with other social service agencies from baseline year 1 to year 3	• Division of Early Childhood Care and Development Administrative Data (DECCD) • Family Wise Web Database	Monthly/Data retrieved by DECCD	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Benchmark VI. Coordination and Referrals for Other Community Resources and Supports						
Information sharing: # of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Total # of **social service agencies** that engage in regular communication with the home visiting provider (Outcome)	Total # of social service agencies that engage in regular communication with the home visiting provider	Increase the total # of social service agencies that engage in regular communication with the home visiting provider from baseline year 1 to year 3	• DECCD • Family Wise Web Database	Monthly/Data retrieved by DECCD	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time
Number of completed referrals	Percent of completed referrals for **families** where receipt of services can be confirmed (Outcome)	# of referrals of participating families with identified needs whose receipt of service was verified as being confirmed / # families who verifiably received services	Increase percentage of completed referrals in families for which receipt of services can be confirmed from baseline year 1 to year 3	• DECCD • Family Wise Web Database	Monthly/Data retrieved by DECCD	Monthly report to CQI Team/program workers/community stakeholders showing accuracy & changes over time

Section VI: Administration Plan

Fiscal and programmatic oversight of Healthy Homes Mississippi will be with the Mississippi Department of Human Services, Division of Early Childhood Care and Development. Placing the program under the auspices of MDHS appeared to be the most pragmatic approach because a) the agency has experience in implementing programs of this nature on a statewide basis; and b) publishing a Request for Proposal for administration of the program would result in diverting funds that could be used to provide services for families.

The following section outlines the staffing plan for HHM. The number of staff positions at capacity is indicated, as well as a brief summary statement of position responsibilities. The organizational chart shows reporting and supervisory lines.

Program Administrator: (1) Oversees grant management; the overall development and implementation of the program, quality assurance, hiring of project staff; fiscal management of project; evaluation and supervision of other administrative staff;

Program Coordinator: (1) monitors overall implementation of program;

Home Visiting Operations Supervisor: (1) monitors field specific program operations;

Data Analyst: (1) managing data files associated with the project;

Family support worker Supervisor: (5) provides support and supervision to family support worker; balances caseloads; helps staff with families; arranges training; will also serve as Assessment Coordinators as dictated by HFA.

Supervisors will be hired at the level of DHS Program Manager. This position requires a Master's degree from an accredited four year college/university and two years of related experiences or a Bachelor's degree from an accredited four year college/university and three years related experience.

Family Support Worker (home visitors) (20) provides direct support to families;

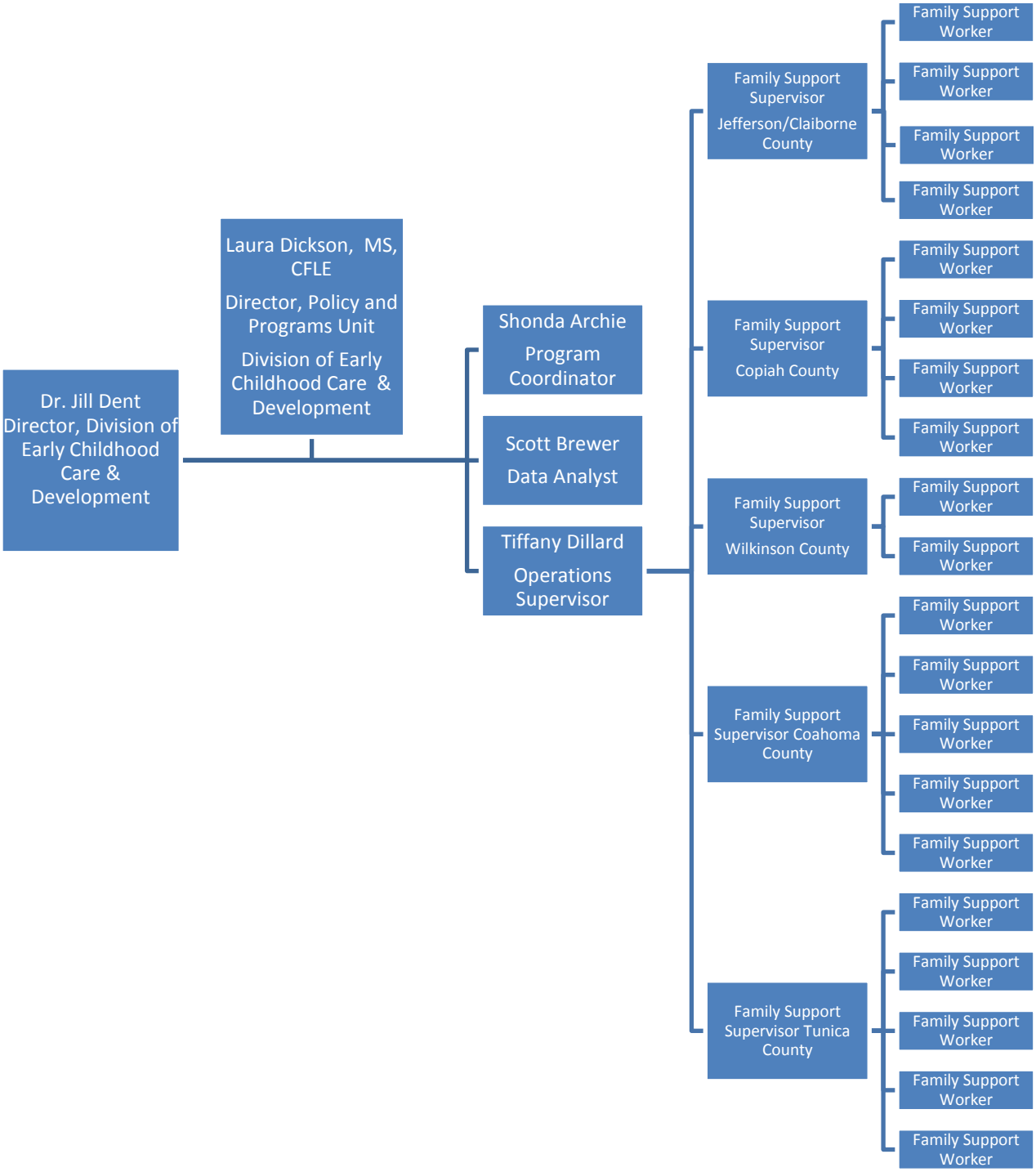
Family support workers will be hired at the level of Program Specialist. The minimum position qualifications are a Bachelor's Degree from an accredited four-year college/ university and two years related experience; or sixty (60) semester hours from an accredited two year or four year college or university and four years of related experience.

In addition to the minimal educational and experience requirements, recruitment efforts will target those individuals who demonstrate the capacity to establish rapport with the families and effectively deliver the home visiting curriculum. Priority consideration will be given to candidates who reside in the community and/or county in which they will work.

DECCD also will sub-contract with an as yet identified agency to provide marriage and family therapy services to all participating families. At this time it has not been determined how many

therapists and supervisors will work on this project; however, it is reasonable to assume a caseload of 15-20 families per therapist. The process for subcontracting will adhere to the relevant policies and procedures of the Mississippi Department of Human Services.

Organizational Chart:



Coordination and Strategies SECAC

Coordination of services for families is an essential component of the Healthy Homes Mississippi program. Moreover, collaboration among community partners in this effort will further the State's goal of developing an integrated system of early childhood care. In 2008, the Governor of Mississippi established a State Early Childhood Advisory Council (SECAC) which is charged with, "developing recommendations for increasing access to high quality state and federal early childhood care and education programs for all children- including those in underrepresented and special populations- and conducting a periodic state needs assessment of the quality and availability of programs. The Council also addresses recommendations for the development of a comprehensive early childhood data system, a statewide professional development system, and research-based early learning standards," (National Governor's Association, Center for Best Practices, 2010.)

The SECAC has agreed to serve as the statewide advisory board for Healthy Homes Mississippi. It is anticipated that this relationship will facilitate the integration of HHM into a statewide coordinated system of care at both the community and the state level. (A discussion of local advisory boards is in Section IV). HHM will benefit from this alliance as it taps into an existing structure of organizations and agencies that is tasked with improving the early childhood experiences of some of our most vulnerable citizens.

Public and Private Partners

Community partnerships and collaborations are essential to the success of this project. These relationships will contribute to resource development and the process of integrating HHM into a network of early childhood programming. We have initiated the process of engaging community partners and have had contact with the following:

AFJC Community Action Agency

Friends of Children (Head Start Agency)

Mississippi Action for Progress (community based family development and family services program for children in low-income families)

Mississippi State Department of Health

State Early Childhood Advisory Council (members and agency affiliations are listed below)

Dr. Cathy Grace, Director, Early Childhood Institute, Mississippi State University
Mr. Richard Berry, Deputy Administrator for Programs, MS Department of Human Services
Dr. Jill Dent, Director, Office of Children and Youth, MS Department of Human Services
Dr. Lynn House, Deputy State Superintendent, MS Department of Education
Ms Nita Norphlet-Thompson, Executive Director, Mississippi Head Start Association
Ms. Tanya Tullos, Director, Early Childhood Education, Mississippi Band of Choctaw Indians
Ms. Holly Spivey, MS Head Start Collaboration Director, Office of Governor Haley Barbour

Ms. Nadine Coleman, Director, Center for Families and Children, Petal School District
Dr. Louise E. Davis, Extension Professor, Child & Family Development
Dr. Fiona Qualls, Assoc Exec Dir for Academic Affairs, State Board for Community & Junior Colleges
Ms. Margarette Davenport, Clay County Day Care Center, Inc.
Susan Boone, Part C Coordinator, First Steps Early Intervention Program, Mississippi State Department of Health
Mr. Festus Simkins, Bureau Director, Office of Licensure, Mississippi State Department of Health
Ms. Gay Logan, Division Director, Child Care Facilities Licensure Division, Mississippi State Department of Health
Ms. Lisa Romine, Bureau of Interdisciplinary Programs, MS Department of Mental Health
Mr. Johnny Franklin, K-12 Education Policy Advisor
Ms. Rhea Williams-Bishop, MS Center for Education Innovation
Mr. Steve Renfroe, Policy, Public and Government Affairs, Mississippi Chevron
Karen C. Fox, Ph.D., Delta Health Alliance
Ms. Oleta Fitzgerald, Executive Director, Children's Defense Fund

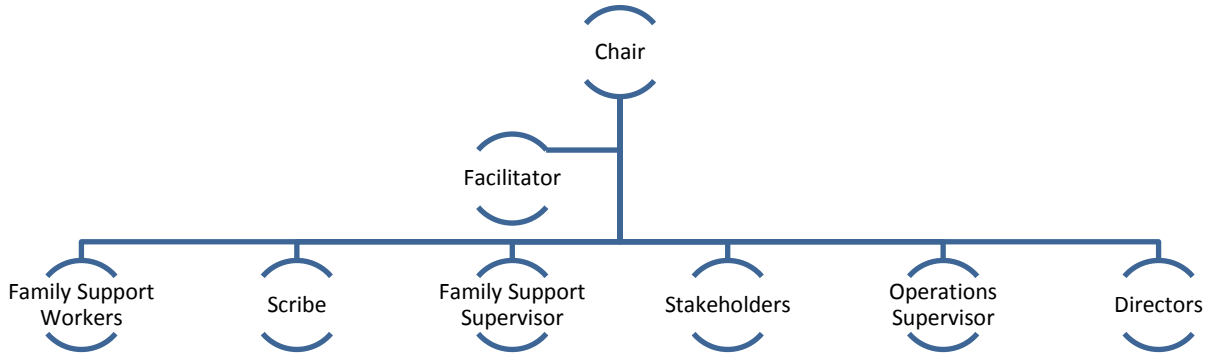
Section VII: Continuous Quality Improvement Plan

The quality assistance plan will address both program content and program service delivery. Elements of the plan will utilize both qualitative and quantitative methods to include (but will not be limited to) site visits; review of client files; and review of quantitative data.

Brief overview of CQI Team structure:

The CQI team is made up of individuals both in and outside of the DECCD, ensuring that a comprehensive representation for quality improvement exists for the program and reaches the community as well as the state level. The following is an overview of the CQI team and its structure:

- **CQI Chair**—this role will be managed by the HHM Program Coordinator. The Chair will oversee the management of the CQI Team, lead discussions during CQI meetings, encourage input and strongly advocate the continuous quality improvement process.
- **CQI Facilitator**—this role will be managed by the Data Analyst. The CQI Facilitator will schedule CQI Team meetings as well as design and brief results of previous month data to include identification of major problem areas.
- **Scribe**—this role will be managed by DECCD support staff. The scribe will take detailed minutes of the meeting.
- **CQI Members**—CQI members will consist of:
    - Director, Division of Early Childhood Care and Development
    - Director, Policy and Programs Unit
    - 1 family support worker from each county group
    - 1 family support supervisor from each county group
    - 1 stakeholder from each county group
    - The Home Visiting Operations Supervisor



Steps for Data Gathering

Family support workers utilize LSP, Family Wise, EPDS, ASQ, HFPI, NCFAS, Partners for a Healthy Baby curriculum, and Family & Children's Services administrative data as resources to gather data for benchmarks and CQI studies. All data will be gathered into the Family Wise database. This database is a cloud-based web application that is updated in real time and produces real time reports. This includes program administration, research, evaluation, and ad hoc reporting, allowing connection to financial centers, administrators and evaluators.

The data analyst is responsible for producing recurring weekly, monthly, quarterly, semi-annual and annual reports as part of the structure for the Monthly CQI Team Brief. This brief will discuss monthly changes in all benchmark areas as required by the Supplemental Information Request (SIR). Data from the Family Wise Database will also be exported to Microsoft Excel for the purpose of data mining and will be added to the Mississippi Longitudinal Data System to ensure data connections within the Early Childhood System; both databases use standardized XML formatting thus enabling a seamless transfer of information. All identifiers will be stripped from the data before it is merged with the Mississippi Longitudinal Data System.

Data mining will include fundamental statistical analysis to observe unusual activities within the scope of the benchmarks. Both qualitative and quantitative analysis will assist in the production of the Monthly CQI Team Brief. In addition, the data analyst will utilize the following CQI methods to present the Monthly CQI Team Brief:

1. Identify specific trends or anomalies;
2. Design a specific one or two paragraph analysis of the trend or anomaly;
3. Provide a break down in key areas or components;
4. Discuss probable root causes;
5. Highlight previous trends or anomalies which have been corrected;
6. Brief will utilize charts and graphical representations in addition to numerical data to illustrate performance indicators associated with processes and outcomes.

Monthly CQI Team Meeting

The meeting will begin with initial comments by either the Director of Early Childhood Care and Development or by the Director of Policy and Programs. The remainder of the meeting is outlined as follows:

1. Brief presented by the data analyst
2. During the brief, comments will be open for discussion of root cause analysis
3. CQI Chair will engage team members in discussion of trends, anomalies, and recommendations to improve processes and outcomes.
4. Scribe will ensure copious notes of all comments and recommendations.
5. CQI Chair will discuss any housekeeping requirements and plan next meeting.
6. Director(s) will conclude meeting with final analysis and input.

7. Scribe will draft monthly minutes for distribution to CQI team members.
8. Results of CQI meeting will inform program implementation and operations and will be shared with home visiting staff by the appropriate supervisory personnel

Research Methods

The CQI Team will utilize qualitative research methods in the following manner:

- Family support workers will conduct in-depth interviews and utilize notes to document particular themes that emerge
- CQI Monthly Team Meetings will also serve as an opportunity to act as a focus group on a particular theme(s) presented during the session
- Reports from Database can be exported to a word document an examined for recurring and/or similar words to draw out themes and trends

The CQI Team will utilize quantitative research methods in the following manner:

- Surveys contain scale scores that will be quantitatively analyzed
- Federal Benchmark definitions will be tracked and analyzed for changes over time
- Family support workers will conduct structured interviews

MDHS/HHM will subcontract with the Social Science Research Center (SSRC) at Mississippi State University to conduct an evaluation of the home visiting program. The evaluation will examine both processes and outcomes.

The evaluation process will be used as a tool to guide program development and implementation as well as provide objective data from which to measure program processes and effectiveness. The evaluation approach will include a participatory and collaborative effort between program personnel, program evaluators and community residents and/or program participants. This strategy is designed to create ownership of the evaluation at all levels, with the assumption that these efforts will result in increased cooperation throughout the evaluation process and a more productive use of the evaluation product. Involvement of all parties will clarify the specific goals and objectives and the standards by which these processes are to be measured. At this level, the evaluation itself is viewed as an ongoing iterative process; it is anticipated that these data will be integrated into program delivery and management, as well as provide objective measures or outcomes to assess program effectiveness.

MSU/SSRC will develop the research design, conduct data analysis (qualitative and quantitative) using data collected through Family Wise, collect additional data as needed and provide an evaluation report.

The subcontract with MSU will be issued in accordance with the policies and procedures of the Mississippi Department of Human Services.

Section VIII: Technical Assistance Needs

Mississippi has identified the following topics for technical assistance: (1) support for rapid home visiting home expansion, (2) retention of families participating in HHM, (3) supporting HHM cohesiveness with multiple sites and (4) prevention of family support worker burnout.

Section IX: Reporting Requirements

The State of Mississippi will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program to address: state home visiting program goals and objectives; implementation of home visiting program in targeted at risk communities; progress toward meeting legislatively mandated benchmarks; home visiting program's CQI efforts; administration of home visiting program; and technical assistance needs.